SLEEP DISORDER ASSOCIATES HIPAA PRIVACY POLICY

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization:

Treatment: including, but not limited to, inpatient, outpatient or psychiatric care.

To your treating physician(s). Payment: including, but not limited to, asking you about your health care plan(s), or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts, either ourselves or through a collection agency or attorney. Health care operations: including, but not limited to, financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. Disclosures when release is authorized by law: including, but not limited to, judicial settings and to health oversight regulatory agencies, law enforcement and correctional institutions. Uses or disclosures for specialized government functions: including, but not limited to, the protection of the President or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services. In emergency situations or to avert serious health / safety situations. If you are a member of the armed forces, we may release medical information about you and your dependents as requested by military command authorities. Disclosures of de-identified information. Disclosures relating to worker's compensation claims. To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties. To organizations that handle organ and tissue donations. To public health organizations or federal organizations in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication). Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) You may be contacted by the hospital to remind you of any appointments, healthcare treatment alternatives and

other health-related benefits and services offered by the hospital. We may disclose personal health information to a patient's spouse for the purpose of scheduling an appointment and/or discussing treatment information, unless otherwise directed in writing by the patient.

Personal Privacy Protection Directive

In accordance with Sleep Disorder Associates. Notice of Privacy Practices and to protect the confidentiality of my protected health information, I hereby direct that disclosure of my protected health information be restricted. Specifically, no documentation of any information related to my stay or treatment, including but not limited to, any documents or other materials prepared for peer review, risk management, or quality assurance purposes, is to be disclosed under any circumstances, redacted or otherwise, to anyone not affiliated with Sleep Disorder Associates**.,** for any purpose other than payment or legitimate health care operations, without my express written consent or the express written consent of my authorized representative.

Other Uses and Disclosures:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

Your Rights: You have the following rights concerning your protected health information (PHI):

Restrictions: To request restricted access to all or part of your protected health information (PHI). To do this, contact the HIPAA Privacy and Security Officer. We are not required to grant your request and you do not have the right to restrict disclosures required by law. If we do agree, we must honor the restrictions you request.

Confidential Communications: To receive correspondence of confidential information by alternate means or location such as phoning you at work rather than at home or mailing your health information to a different address. To do this, contact the HIPAA Privacy and Security Officer. We will take reasonable actions to accommodate your request.

Access: To inspect or receive copies of your protected health information (PHI). To do this, contact the HIPAA Privacy and Security Officer. In certain circumstances you may not have the right to access your records if Sleep Disorder Associates. reasonably believes (or has reason to believe) that such access would cause harm. Examples include, but are not limited to, certain psychotherapy notes, information compiled in reasonable anticipation of or for use in civil, criminal or administrative actions or proceedings, or information obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Amendments / Corrections: To request changes be made to your protected health information (PHI). To do this, contact the HIPAA Privacy and Security Officer. We are not required to grant your request if we did not create the record or the record is accurate and complete. If we deny your request for amendment / correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we agree to the request, we will make the correction within 60 days and will send the corrected information to persons we know who got the wrong information, and others you specify.

Accounting: To receive an accounting of the disclosures by us of your protected health information (PHI) in the Seven years (or shorter time) prior to your request. To do this, contact the HIPAA Privacy and Security Officer. By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. you are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. We are not required to give you a list of disclosures that occurred before April 14, 2003.

This Notice: To get updates or reissue of this notice, at your request.

Complaints: To complain to us or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, contact 717-399-0030 The law forbids us from taking retaliatory action against you if you complain.

Our Duties: We are required by law to maintain the privacy of your protected health information (PHI). We must abide by the terms of this notice or any update of this notice. **Privacy Contact:** For more information about our privacy practices, please contact:

SLEEP DISORDER ASSOCIATES
Privacy and Security Officer
250 Ranck Ave
Lancaster, PA 17602
Phone 717-399-7451
Toll Free 1-866-251-7451

SLEEP DISORDER ASSOCIATES. FINANCIAL POLICY

Sleep Disorder Associates. is committed to providing you with the best care possible. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. **Payment for services is due at the time services are rendered, except as outlined below.** We accept cash, checks, MasterCard, VISA, Discover and American Express. Any outstanding balances are due within 30 days, unless prior arrangements have been made with the Billing Department. All balances that reach 90 days or older may be sent to a collection agency. We will gladly try to answer any questions relating to your insurance, but insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. **You must realize, however, that your insurance is a contract between you, your employer (possibly), and the insurance company.** As such, you are responsible to know where services are to be performed. It is important that as questions arise you contact your insurance company directly for final guidance and clarification. **IF WE DO PARTICIPATE WITH YOUR INSURANCE COMPANY,** all services performed in our office will be submitted to your insurance, unless we have received prior notification of non-covered services. All co-pays are due at the time of service. Deductibles and co-insurances are your responsibility and will be billed to you by our office. HMO insurances may require referrals for services. ***It is your responsibility to obtain the referral prior to the time of the service.*** If a referral is NOT presented at the time of service, you will be responsible for payment in full for that service. You are responsible for all co-payments and deductibles.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY, we will bill your insurance carrier as a courtesy, but we will not accept payment from them as payment in full for services performed. All insurance carriers have a schedule of fees from which they pay; however, the facility's fee may be more than what the insurance company shows on their schedule. Therefore, any balances not covered by the insurance company become your responsibility. Payment for services is due at the time of service. We must emphasize that as a DME provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date services are rendered. Therefore, it is often necessary for you to inquire and explore your benefits directly with your insurance carrier. We realize that temporary financial problems may affect timely payment of your account. If such problems to arise, we encourage you to contact our billing department for assistance in the management of your account.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION I hereby assign and grant to Sleep Disorder Associates. all rights and interests to which I may be entitled under any insurance policy, Medicare or any other fund or third party payment plan responsible for payment of my benefits. I hereby authorize Sleep Disorder Associates. to release all information, including all or any part of my medical records, necessary to obtain payment to my insurance company, employer (worker's compensation only), Medicare, Medicaid, or other fund or third party payor, which may be responsible for payment of my benefits.

PAYMENT AND COLLECTION I acknowledge that if my insurance company sends a check for payment of the insurance benefits to me, either in error or because of insurance company policy, I agree to endorse and deliver the check to Sleep Disorder Associates. I understand that by virtue of the assignment described in this Consent, any funds I receive belong to Sleep Disorder Associates. and that is unlawful to use or apply the funds in any other way. In the event the insurance company check is more than the outstanding physician bill, satisfactory arrangements can be made between Sleep Disorder Associates. and the undersigned. I agree that I am responsible for payment of established charges currently in effect to the extent that said charges are not covered, allowed or paid by my insurance company, Medicare, or any other fund or third party payor. I understand I will not be responsible for the Payment of any of those charges that Sleep Disorder Associates. is restricted from collecting by law or agreement. In the event that any monies paid by me results in an overpayment of $10.00 or less, those monies will be applied first to any previous balance I may have and/or will remain on my account as a credit to a future visit. I may at any time request in writing any credited funds available on my account. In the event the account remains unpaid, Sleep Disorder Associates. may turn the account over to collections. I agree to pay Sleep Disorder Associates. reasonable collection costs as allowed by the laws of the Commonwealth of Pennsylvania. I will be responsible for any and all costs associated with collection of my account, including any reasonable attorneys' fees. I have read and fully understand the financial policy set forth by Sleep Disorder Associates. and I agree to the terms of this policy. I also understand and agree that the terms of the financial policy may be amended by the practice at any time without prior notification.

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PATIENT SIGNATURE DATE

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PRINT NAME